Pain & Rehabilitative
CONSULTANTS MEDICAL GROUP

Babak Jamasbi, MD | Brendan Morley, MD
Timothy Lo, MD | Arzhang Zereshki, MD | Neil Kamdar, MD | John Alchemy, MD

1335 Stanford Avenue, Emeryville, CA 94608 | Phone: (510) 647-5101 | Fax: (510) 647-5105

Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Jessica Aikin, PA-C

Encounter Date: Aug 07, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 41 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

SUBJECTIVE COMPLAINTS:
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Patient is here to follow up on pain in his arms and bilateral hands.

Patient denies acute changes to his pain today. continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

The patient did see Dr. Leonard Gordon on July 22, 2020, regarding ulnar mononeuropathy at the bilateral elbows as seen on most recent EMG. Per the patient, Dr. gordon feels that this may have been a misdiagnosis and he did not recommend surgery.

Our request for 12 additional sessions of acupuncture treatment has been denied, according to the patient. We do not yet have this denial letter, but will review when made available so that we can appeal. As previously discussed with acupuncture treatment, he reports a reduction in his pain complaints from a 4-5/10 to a 2-3/10, constituting a 10-20% reduction in his pain complaints for 2-3 days. His pain is made worse with massage therapy.

With regard to medication, he continues with Lidocaine cream and voltaren gel as topical medications. He denies side effects with his medications. He does request for refills today.

OBJECTIVE FINDINGS:
Mental Status: The patient is awake, alert and fully oriented with normal speech and language. Appropriately conversant, pleasant, cooperates with exam.

Spine:
Upright spinal posture

Motor:
Patient is able to stand up from a chair unassisted.
Gait is narrow based and steady.

UE/LE muscle strength:
Bilateral upper and lower extremity strength appear intact on non-confrontational movement exam, without evidence for foot drop or other observable weakness. Normal bulk and tone. No atrophy noted.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply to affected area daily
3. Advil (OTC)
4. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
Surgical Consult (99205) Neck.

Trigger point injections to be done in office for the bilateral trapezius musculature.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821	Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822	Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831	Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20	Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:
Refill Added:
1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00.
2 Voltaren 1% Gel SIG: Apply to affected area daily QTY: 1.00.

TREATMENT PLAN:
***

Assessment:
This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:
- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per the patient, he is not being recommended for surgery. We will request for Dr. Gordon's report.

- The patient has a QME re-evaluation with Dr. Stoller, which has now been postponed until January 2021.

- Per the patient, our recent request for 12 additional sessions of acupuncture has been denied.

We will appeal this based on functional improvement as discussed above.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. Our request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the bilateral upper arms. We will re-request for surgical consultation for the neck today as this was included in his QME.

- We will request for TPI in the bilateral trapezius region.

- We did discuss his work restrictions today. He has significant pain in his arms with extended periods of typing and computer work, therefore we have updated his work restrictions to reflect this today.

- With regard to medications, Voltaren gel and Lidocaine ointment refilled today.

Follow up in 4-6 weeks.

WORK STATUS:
***
WORK STATUS: The patient is not permanent and stationary.

Work restrictions:
- Repetitive activities using upper extremities limited to 1 hour in an 8 hour shift.
- Light computer work for up to an hour for an 8 hour shift.
-No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
Greater than 50% of the visit was spent in counseling and coordination of care. As such, time spent with the patient should be the guiding determinant in determining the level of evaluation and management services. 15 minutes were spent in direct face to face time with the patient. "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:

Lidocaine cream: The following has been recommended regarding Lidocaine in the ODG guidelines:

Lidocaine: Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. See Criteria for use below. Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. Indications: Recommended for localized pain that is consistent with a neuropathic etiology after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine patches are generally not recommended for non-neuropathic pain (including osteoarthritis or myofascial pain/trigger points). See Criteria for use below. Most studies have utilized the Neuropathic Pain Scale (NPS) as measure of neuropathy when there are questions of whether this is the cause of pain. There is limited information as to long-term efficacy and continued information as to outcomes should be provided to allow for on-going use. (Argoff, 2004) (Galer, 2004) (Argoff, 2006) (Dworkin, 2007) (Khaliq-2009) (Burch, 2004) (Gimbel, 2005) (Dworkin, 2003) (Finnerup, 2005) (O'Connor, 2009) Discussion about specific details of these studies are given in detail with references. Trigger points & myofascial pain: Not recommended. (Affaitati, 2009) (Dalpaiz, 2004) Osteoarthritis of the knee: Not generally recommended unless a component of neuropathy is indicated using measures such as the Neuropathic Pain Scale. All current available studies were sponsored by the manufacturer of lidocaine patches and are non-controlled, and of short-term in duration. (Burch, 2004) (Kivitz, 2008) Axial back pain (including osteoarthritis): Not recommended unless neuropathy is suggested. Current studies as to use of Lidoderm patches

for non-neuropathic low back pain are non-controlled, may or may not evaluate for the presence of neuropathic quality, have included multiple stages of pain (from acute to chronic), have included multiple diagnoses, show limited results in pain reduction, and are generally sponsored by the manufacturer. Acute groups have had better results than chronic pain patients, which may be attributed to natural recovery. (Gimbel, 2005) (Galer, 2004) (Argoff, 2004) The FDA has approved a Lidocaine/ tetracaine cream (Pliaglis®) for local analgesia. This is only indicated for superficial aesthetic procedures, such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. (FDA, 2013).

Voltaren Gel: The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating

physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:
Kweller, Esq., Zachary : 08/11/2020
Castro, Mario : 08/11/2020
UR, Chubb : 08/12/2020

This visit note has been electronically signed off by Aikin, Jessica, PA-C on 08/07/2020

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Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Jessica Aikin, PA-C

Encounter Date: Jul 10, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
DOB: Sep 27, 1978 Age: 41 Year
Race: Unreported/Refused to Report
Address: 1000 Sutter St Room 123, San Francisco CA 94109 Pref. Phone(H): 415-312-4029
Primary Dr.: Babak Jamasbi, M.D.

Referred By: Babak Jamasbi, M.D.
Injury Date: 02/15/2019
Employer: Biotelemetry, Inc
Case Insurance: Chubb Son of Federal Ins Company
Claim No.: 040519008736

VISIT TYPE:
PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT:

Mr. Shockley was not physically able to come into the office today due to compliance with the current National Emergency guidelines for the COVID-19 pandemic; therefore, a telemedicine follow-up visit was done today. The nature of telehealth consultation was discussed with the patient, including the risks, benefits and alternatives. The patient had opportunity to ask questions about the information and those questions were answered. The patient verbalized understanding and agreed to this telehealth consultation.

SUBJECTIVE COMPLAINTS:

***
Patient is here to follow up on pain in his arms and bilateral hands.

Patient continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

He has been approved for a surgical consultation for the bilateral elbows with Dr. Leonard Gordon to discuss ulnar mononeuropathy at the bilateral elbows. This appointment is scheduled for July 22, 2020.

With acupuncture treatment, he reports a reduction in his pain complaints from a 4-5/10 to a 2-3/10, constituting a 10-20% reduction in his pain complaints for 2-3 days. He would like to continue with this treatment modality.

With regard to medication, he continues with Lidocaine cream and voltaren gel as topical medications. He denies side effects with his medications. He does request for refills today.

Medical History:
***
PAST MEDICAL HISTORY
1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY
1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:
***
PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.
The patient has a significant other.

The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

OBJECTIVE FINDINGS:
Mental Status: The patient is awake, alert and fully oriented with normal speech and language. Appropriately conversant, pleasant, cooperates with exam.

Spine:
Upright spinal posture

Motor:
Patient is able to stand up from a chair unassisted.
Gait is narrow based and steady.

UE/LE muscle strength:
Bilateral upper and lower extremity strength appear intact on non-confrontational movement exam, without evidence for foot drop or other observable weakness. Normal bulk and tone. No atrophy noted.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply to affected area daily
3. Advil (OTC)
4. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
for bilateral hands, wrists, and forearms.

12 sessions of acupuncture 97813, 97814, 97026, 97124.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:

M50.10	Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821	Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822	Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831	Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20	Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:
Refill Added:

1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00.
2 Voltaren 1% Gel SIG: Apply to affected area daily QTY: 1.00.

TREATMENT PLAN:
***

Assessment:
This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyclinating ulnar mononcuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:
- With regard to the bilateral elbows, he has been approved for a surgical consult to address bilateral ulnar neuropathy with Dr. Leonard Gordon. He is scheduled on 7/22/20.

- The patient has a QME re-evaluation with Dr. Stoller on August 20, 2020.

- The patient continues with acupuncture treatment at this time, with benefit. We will request for 12 additional sessions based on functional improvement as discussed above.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. The severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed the possibility of CESI, the patient defers injections. Our request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the bilateral upper arms. He will continue to discuss this with his attorney.

- With regard to medications, Voltaren gel and Lidocaine ointment refilled today.

Follow up in 4-6 weeks.

WORK STATUS:
***
WORK STATUS: The patient is not permanent and stationary.

Work restrictions: Repetitive activities using upper extremities limited to 1 hour in an 8-hour shift. No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
Greater than 50% of the visit was spent in counseling and coordination of care. As such, time spent with the patient should be the guiding determinant in determining the level of evaluation and management services. 15 minutes were spent in direct face to face time with the patient. "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request. *Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
Diclofenac cream: The following has been recommended regarding Diclofenac in the MTUS/ACOEM guidelines

Topical NSAIDs for Chronic Persistent Pain Where Target Tissue Superficially Located Recommended.

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Lidocaine cream: The following has been recommended regarding Lidocaine in the ODG guidelines:

Lidocaine: Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. See Criteria for use below. Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. Indications: Recommended for localized pain that is consistent with a neuropathic etiology after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine patches are generally not recommended for non-neuropathic pain (including osteoarthritis or myofascial pain/trigger points). See Criteria for use below. Most studies have utilized the Neuropathic Pain Scale (NPS) as measure of neuropathy when there are questions of whether this is the cause of pain. There is limited information as to long-term efficacy and continued information as to outcomes should be provided to allow for on-going use. (Argoff, 2004) (Galer, 2004) (Argoff, 2006) (Dworkin, 2007) (Khaliq-2009) (Burch, 2004) (Gimbel, 2005) (Dworkin, 2003) (Finnerup, 2005) (O'Connor, 2009) Discussion about specific details of these studies are given in detail with

references. Trigger points & myofascial pain: Not recommended. (Affaitati, 2009) (Dalpaiz, 2004) Osteoarthritis of the knee: Not generally recommended unless a component of neuropathy is indicated using measures such as the Neuropathic Pain Scale. All current available studies were sponsored by the manufacturer of lidocaine patches and are non-controlled, and of short-term in duration. (Burch, 2004) (Kivitz, 2008) Axial back pain (including osteoarthritis): Not recommended unless neuropathy is suggested. Current studies as to use of Lidoderm patches for non-neuropathic low back pain are non-controlled, may or may not evaluate for the presence of neuropathic quality, have included multiple stages of pain (from acute to chronic), have included multiple diagnoses, show limited results in pain reduction, and are generally sponsored by the manufacturer. Acute groups have had better results than chronic pain patients, which may be attributed to natural recovery. (Gimbel, 2005) (Galer, 2004) (Argoff, 2004) The FDA has approved a Lidocaine/ tetracaine cream (Pliaglis®) for local analgesia. This is only indicated for superficial aesthetic procedures, such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. (FDA, 2013).

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:
Kweller, Esq., Zachary : 07/13/2020
Castro, Mario : 07/13/2020
Kweller, Esq., Zachary : 07/14/2020
Castro, Mario : 07/14/2020
UR, Chubb : 07/14/2020
UR, Chubb : 08/26/2020

This visit note has been electronically signed off by Jamasbi, Babak J,, M.D. on 07/17/2020

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Visit Note

Provider:
Supervising: Babak J, Jamasbi, M.D.
Performing: Jessica Aikin, PA-C

Encounter Date: Sep 04, 2020
Patient: Shockley, Jonathan (PT00023609)
Sex: Male
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Primary Dr.: Babak Jamasbi, M.D.

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SUBJECTIVE COMPLAINTS:
***
Patient is here to follow up on pain in his arms and bilateral hands.

Patient continues to report bilateral arm pain, with pain in his bilateral upper extremities, right greater than left. Pain radiates from his hands and wrists up to his elbows and he has pain in his right deltoid region and shoulder. Pain is described as burning and "pulling". He reports pain in his neck as well as numbness and tingling into his right 4th and 5th digit. Pain is worse with activity and better with conservative treatment.

The patient did see Dr. Leonard Gordon on July 22, 2020, regarding ulnar mononeuropathy at the bilateral elbows as seen on most recent EMG. He has also had a new EMG of the bilateral upper extremities done with Dr. Liberty Jenkins, neurologist. Per the patient, this also confirmed ulnar neuropathy.

Our request for 12 sessions of acupuncture treatment was denied and is in the process of appeal. In the meantime, he would be interested in trying aqua therapy.

With regard to medication, he continues with Lidocaine cream and voltaren gel as topical medications. He denies side effects with his medications. He does request for refills today.

Medical History:
***
PAST MEDICAL HISTORY
1. Bronchitis 2 years ago.
2. Eczema.
3. He had an episode of epilepsy and took Tegretol at age 10 or 11.
4. History of anxiety. He was taking Hydroxyzine but now does not take medication and just meditates.

PAST SURGICAL HISTORY
1. Adenoidectomy in 1987.
2. Lasik surgery in 2000.
3. Sympathectomy in 2000.
4. Right big toe bone spur removal in 2000.
5. Right Achilles tendon debridement in 2002.
6. Right Achilles tendon debridement in 2003.

Social History:
***
PSYCH/SOCIAL HISTORY
The patient does not smoke cigarettes.
The patient does not drink alcoholic beverages.
The patient does not use illicit drugs.
The patient is not married.

The patient has a significant other.
The patient has no children.
Patient does not have a family history of childhood abuse.
Patient does not have a family history of sexual abuse.
Epworth Scale is 0. The patient goes to bed, falls asleep and wakes up at variable times. The patient feels he gets adequate rest.

OBJECTIVE FINDINGS:
Mental Status: The patient is awake, alert and fully oriented with normal speech and language. Appropriately conversant, pleasant, cooperates with exam.

Spine:
Upright spinal posture

Motor:
Patient is able to stand up from a chair unassisted.
Gait is narrow based and steady.

UE/LE muscle strength:
Bilateral upper and lower extremity strength appear intact on non-confrontational movement exam, without evidence for foot drop or other observable weakness. Normal bulk and tone. No atrophy noted.

Current Medications:
1. Lidocaine 5% Ointment Apply 2-3 grams to affected area up to 4 times daily
2. Voltaren 1% Gel Apply to affected area daily
3. Advil (OTC)
4. Aspirin Ec 81 Mg Tablet (OTC)

FORMAL REQUEST FOR AUTHORIZATION:
6 sessions of Aquatic Therapy (97113) Elbow Bilateral Elbows Wrist Bilateral Wrists Hand Bilateral Hands.

This is a formal request for authorization of the medications within the "prescriptions" section of this note.

DIAGNOSIS:
M50.10 Cervical disc disorder with radiculopathy, unspecified cervical region
M70.821 Other soft tissue disorders related to use, overuse and pressure, right upper arm
M70.822 Other soft tissue disorders related to use, overuse and pressure, left upper arm
M70.831 Other soft tissue disorders related to use, overuse and pressure, right forearm
G56.20 Lesion of ulnar nerve, unspecified upper limb

PRESCRIPTION:
1 Gabapentin 300 Mg Capsule SIG: Take one QHS QTY: 30.00.

Refill Added:
1 Lidocaine 5% Ointment SIG: Apply 2-3 grams to affected area up to 4 times daily QTY: 60.00.
2 Voltaren 1% Gel SIG: Apply to affected area daily QTY: 1.00.

TREATMENT PLAN:
***

Assessment:
This patient was injured during the course of his usual and customary work. The patient has worked as an EKG technician and his requires him to perform repetitive activity using his hands. Massage therapy exacerbated his pain. He is not currently working.

The patient did have a QME with Dr. Stoller on 1/23/20. Per Dr. Stoller, the patient is not yet MMI. He recommends an upper extremity EMG to asses his neuropathic symptoms as well as a cervical spine MRI to rule out radiculopathy. Cervical MRI was completed on 4/3/20 and is reviewed below, EMG was completed on 2/10/20 with Dr. Neeti Bathia, this shows demyelinating ulnar mononeuropathy bilaterally across the elbows, no evidence of median, radial, or cervical radiculopathy on either side.

Plan:
- With regard to the bilateral elbows, he was approved for a surgical consult to address bilateral ulnar neuropathy and did see Dr. Leonard Gordon on 7/22/20. Per the patient, he is not being recommended for surgery. We will request for Dr. Gordon's report as well as Dr. Liberty Jenkins new EMG report today.

- The patient has a QME re-evaluation with Dr. Stoller, which has now been postponed until January 2021.

- Our recent request for 12 additional sessions of acupuncture has been denied and will be appealed based on functional improvement that was documented at his last clinic visit. At this time we will request for 6 sessions of aqua therapy for his wrists, hands, and elbows.

- With regard to the cervical spine, MRI of the cervical spine from 4/3/20 shows a 4mm left disc osteophyte at C5-C6 causing severe bilateral neural foraminal stenosis as well as a left paracentral disc protrusion at C6-C7, mild central stenosis from C5-C7. Severe bilateral neural foraminal stenosis at C5-C6 may be contributing to right shoulder and deltoid pain. We discussed CESI, the patient defers injections. Our request for surgical consultation with Dr. Paul Slosar was deferred on the basis that his insurance is disputing liability for the body parts of the neck and the bilateral upper arms. Our recent re-request for surgical consultation for the neck, as well as TPI in the bilateral trapezius region, were deferred due to dispute of liability of the neck as part of his claim.

- With regard to medications, Voltaren gel and Lidocaine ointment refilled today. We will also trial Gabapentin, we will start him off with 300 mg at night and monitor his response at his next

visit, consider titrating up to full therapeutic dosing if tolerated.

Follow up in 4-6 weeks.

WORK STATUS:
***
WORK STATUS: The patient is not permanent and stationary.

Work restrictions:
- Repetitive activities using upper extremities limited to 1 hour in an 8 hour shift.
- Light computer work for up to an hour for an 8 hour shift.
-No lifting, pushing, or pulling greater than 5 pounds

TIME SPENT:
Greater than 50% of the visit was spent in counseling and coordination of care. As such, time spent with the patient should be the guiding determinant in determining the level of evaluation and management services. 25 minutes were spent in direct face to face time with the patient. "I declare under penalty and perjury that information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and beliefs, except as to information I have indicated that I received from others. As to that information, I declare under penalty of perjury that the information accurately describes the information provided to me, and except as noted herein, that I believe it to be true.

I further declare that I have not violated labor code section 139.3, and have not offered, delivered, received or accepted any rebate, refund, commission, references, patronage dividend of accounts or other consideration, whether in the form of money or otherwise, or compensation or inducement for any referred evaluation or examination."

Please consider the treatment plan as a formal request for preauthorization services described therein. In the event that the written denial, authorization or notice of delay is not received by our office within 7 business days with a description of the review by a qualified physician with training in pain management and/or physical medicine and rehabilitation expertise (as per the dictates of the California Code of Regulation 9792.6) we will assume de facto authorization.

If prior pre-authorization has been requested in an earlier report or therapeutic plan, please consider the date of the prior request as applicable for the purposes of the formal date of request.
*Dr. Morley and Dr. Jamasbi hold a financial interest in Bay Surgery Center. The Northern California Functional Restoration Program is an integral part of Pain and Rehabilitative Consultants Medical Group.

JUSTIFICATION:
Gabapentin (Neurontin): The following has been recommended regarding Gabapentin (Neurontin) in the MTUS/ACOEM guidelines

Anti-convulsant Agents for Neuropathic Pain
Recommended.

Anti-convulsants (Gabapentin, Pregabalin, Mirogabalin, Gabapentin Enacarbil, Lamotrigine, Topiramate, Carbamazepine, and Oxcarbazepine) are moderately recommended for treatment of neuropathic pain.

Strength of Evidence – Moderately Recommended, Evidence (B)

Level of Confidence – High

Indications: Moderate to severe painful neuropathic pain sufficient neuropathic pain to require medication. Generally, anti-convulsants are considered a potential adjunct as a second- or third-line treatment for chronic neuropathic pain, after attempting other treatments (e.g., anti-depressants, aerobic exercise, other exercise).

Benefits: Modest pain reduction. May include reduced sleep disturbance.

Harms: Sedating properties may be intolerable. For some, the sedation is sufficient to impair daytime activities and thus, especially in those cases, be inappropriate for safety sensitive jobs. Also may have adverse effects including nausea, vomiting, dizziness, confusion, somnolence and weight gain.Carbamazepine may be associated with fluid and electrolyte abnormalities. Topiramate may cause kidney stones and ocular toxicity.

Frequency/Dose/Duration: Frequency and dosing are based on the medication prescribed. Duration of use for neuropathic pain patients may be indefinite, although many of these patients do not require indefinite treatment as the condition usually often resolves or improves. Gabapentin dose is initiated usually at 300mg/day and gradually raised.

Indications for Discontinuation: Resolution of pain, lack of efficacy, intolerance, or development of adverse effects. Monitoring of employed patients is indicated due to elevated risks for CNS-sedating adverse effects.

Rationale: There is high and moderate quality evidence of efficacy for multiple anti-convulsants (Gabapentin, Pregabalin, Lamotrigine, Carbazepime and Topiramate) for treatment of peripheral neuropathic pain in comparison with placebo [199][200, 201][191-194, 198, 202]. Although not all studies are positive [195, 196, 1146, 1147], the highest quality studies and those with larger sample sizes suggest efficacy. Nearly all quality evidence is of peripheral neuropathic pain, although at least one quality trial included MS patients [192]. There is not evidence that adding lamotrigine to gabapentin is efficacious [192]. Comparable efficacy has been suggested when comparing gabapentin and nortriptyline [1120]. In a study by Otto 2004, Valproic acid did not prove efficacious, however, in another study divalproex showed efficacy for post-herpetic neuralgia when compared to placebo at 8 weeks [1148]. Anti-convulsants are not invasive, have some adverse effects, are moderate cost, have some quality evidence of efficacy for treatment of neuropathic pain and are recommended.

Evidence: A comprehensive literature search was conducted using PubMed, Scopus, CINAHL, and Google Scholar without date limits using the following terms: neuropathic pain, nerve pain, neuralgia; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 1413 articles in PubMed, 917 in Scopus, 176 in CINAHL, 9,630 in Google Scholar and 0 from other sources. We considered for inclusion 349 from PubMed, 0 from Scopus, 12 from CINAHL, 0 from Google Scholar and 0 from other sources. Of the 361 articles considered for inclusion, 238 randomized controlled trials and 123 systematic reviews met the inclusion criteria. A comprehensive literature search since 2012 was conducted using PubMed using the following terms: diabetic neuropathy; controlled clinical trial, controlled trials, randomized controlled trial, randomized controlled trials, random allocation, random*, randomized, randomization, randomly; systematic, systematic review, retrospective, and prospective studies. We found and reviewed 2423 articles in PubMed and 0 from other sources. We considered for inclusion 19 from PubMed and 0 from other sources. Of the 19 articles considered for inclusion, 13 randomized controlled trials and 0 systematic reviews met the inclusion criteria. There is high-quality and moderate-quality studies incorporated into this analysis. There is low-quality evidence listed in Appendix 4.

Lidocaine cream: The following has been recommended regarding Lidocaine in the ODG guidelines:

Lidocaine: Recommended for a trial if there is evidence of localized pain that is consistent with a neuropathic etiology. See Criteria for use below. Topical lidocaine, in the formulation of a dermal patch (Lidoderm®) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. In February 2007 the FDA notified consumers and healthcare professionals of the potential hazards of the use of topical lidocaine. Those at particular risk were individuals that applied large amounts of this substance over large areas, left the products on for long periods of time, or used the agent with occlusive dressings. Systemic exposure was highly variable among patients. Only FDA-approved products are currently recommended. Indications: Recommended for localized pain that is consistent with a neuropathic etiology after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical lidocaine patches are generally not recommended for non-neuropathic pain (including osteoarthritis or myofascial pain/trigger points). See Criteria for use below. Most studies have utilized the Neuropathic Pain Scale (NPS) as measure of neuropathy when there are questions of whether this is the cause of pain. There is limited information as to long-term efficacy and continued information as to outcomes should be provided to allow for on-going use. (Argoff, 2004) (Galer, 2004) (Argoff, 2006) (Dworkin, 2007) (Khaliq-2009) (Burch, 2004) (Gimbel, 2005) (Dworkin, 2003) (Finnerup, 2005) (O'Connor, 2009) Discussion about specific details of these studies are given in detail with

references. Trigger points & myofascial pain: Not recommended. (Affaitati, 2009) (Dalpaiz, 2004) Osteoarthritis of the knee: Not generally recommended unless a component of neuropathy is indicated using measures such as the Neuropathic Pain Scale. All current available studies were sponsored by the manufacturer of lidocaine patches and are non-controlled, and of short-term in duration. (Burch, 2004) (Kivitz, 2008) Axial back pain (including osteoarthritis): Not recommended unless neuropathy is suggested. Current studies as to use of Lidoderm patches for non-neuropathic low back pain are non-controlled, may or may not evaluate for the presence of neuropathic quality, have included multiple stages of pain (from acute to chronic), have included multiple diagnoses, show limited results in pain reduction, and are generally sponsored by the manufacturer. Acute groups have had better results than chronic pain patients, which may be attributed to natural recovery. (Gimbel, 2005) (Galer, 2004) (Argoff, 2004) The FDA has approved a Lidocaine/ tetracaine cream (Pliaglis®) for local analgesia. This is only indicated for superficial aesthetic procedures, such as dermal filler injection, pulsed dye laser therapy, facial laser resurfacing, and laser-assisted tattoo removal. (FDA, 2013).

Voltaren Gel: The following has been recommended regarding Voltaren gel in the MTUS/ACOEM guidelines

Topical NSAIDs are selectively recommended for treatment of chronic persistent pain where target tissue is superficially located.

Strength of Evidence – Recommended, Insufficient Evidence (I)

Level of Confidence – Low

Indications: Chronic persistent pain in a superficial area that is amenable to a topical agent. Should generally have intolerance of, or another indication against oral NSAID use.

Benefits: Improvement in pain and function. Avoidance of gastrointestinal adverse effects of some NSAIDs.

Harms: Irritation, allergy, having to use on skin that may interfere with some job performance needs

Frequency/Dose/Duration: Per manufacturer's recommendations

Indications for Discontinuation: Resolution, intolerance, adverse effects, or lack of benefits.

Rationale: There are no quality studies of treating chronic persistent pain with topical NSAIDs. The target tissue for most, but not all chronic persistent pain with an occupational basis is generally too deep for justification of use of topical NSAIDs. Topical NSAIDs are not invasive, have low adverse effects, are high cost for a typical treatment regimen, and are selectively recommended for treatment of conditions amenable to topical treatment who generally also have intolerance or other contraindication for oral NSAID use.

Evidence: There are high- and moderate-quality RCTs incorporated into this analysis. There are no quality studies evaluating topical NSAIDs for treatment of chronic persistent pain syndrome.

It has been brought to our attention that on occasion there has been some confusion in regards to prescriptions written from physician assistants and nurse practitioners in this office (Pain and Rehabilitative Consultants Medical Group) working under the direction of the primary treating physician. These prescriptions are not being honored and are refused to be filled by the adjusters because they are written by the physician assistant or nurse practitioner. All of our physician assistants and nurse practitioners are licensed in California and work directly under the supervision of medical doctors. Please refer to the following labor code LC 3209.10 in regards to the legality of physician assistants, nurse practitioners, and primary treating physicians as it relates to the ability to write prescriptions:

LC 3209.10. (a) Medical treatment of a work-related injury required to cure or relieve the effects of the injury may be provided by a state licensed physician assistant or nurse practitioner, acting under the review or supervision of a physician and surgeon pursuant to standardized procedures or protocols within their lawfully authorized scope of practice. The reviewing or supervising physician and surgeon of the physician assistant or nurse practitioner shall be deemed to be the treating physician. For the purposes of this section, "medical treatment" includes the authority of the nurse practitioner or physician assistant to authorize the patient to receive time off from work for a period not to exceed three calendar days if that authority is included in a standardized procedure or protocol approved by the supervising physician. The nurse practitioner or physician assistant may cosign the Doctor's First Report of Occupational Injury or Illness. The treating physician shall make any determination of temporary disability and shall sign the report.

CC:
Kweller, Esq., Zachary : 09/08/2020
Castro, Mario : 09/08/2020
UR, Chubb : 09/08/2020

This visit note has been electronically signed off by Aikin, Jessica, PA-C on 09/04/2020

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September 20, 2020

MEDICAL LEGAL SUPPLEMENTAL REPORT

RE: SHOCKLEY, Jonathan
DOB: 09/27/1978
INSURANCE: Chubb Group Insurance Company
CLAIM #: 7173815490
DOI: 02/15/2019
EMPLOYER: CardioNet

Dear Concerned Parties,

I am in receipt of a July 24, 2020 request for a supplemental report from Mr. Zachary Kweller in the matter of Mr. Jonathan Shockley. I have spent 45 minutes reviewing medical records and 30 minutes drafting editing this report. This will be billed as an ML 106 with 1 hour and 15 minutes being spent.

1. Body parts: Please make an express statement as to whether or not Mr. Shockley sustained an injury to the cervical spine and bilateral upper arms in connection with his excepted CT injury through 2/15/2019.

Mr. Shockley sustained an injury to the cervical musculature due to a cumulative trauma injury through 2/15/2019. This is caused by prolonged periods of neck flexion and rotation while in flexion due to his work position. There is no evidence that he has an injury to his cervical spine.

Mr. Shockley did sustain an injury to his bilateral upper arms due to his feeling of trauma injury through 2/15/2019. This is due to overuse and pressure when to the nerves running through the cubital tunnel with sustained periods of elbow flexion while the patient worked.

Both of these injuries arise out of an act of employment and during the course of employment.

2. TTD/work restrictions: Please clarify the work restrictions for Mr. Shockley considering the restrictions you provided, the restrictions by Dr. Jamasbi, and the restrictions by Dr. Lang.

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Mr. Shockley should not do any repetitive activities using upper extremities for longer than 1 hour in the ER shift. He should not be lifting pushing or pulling greater than 5 pounds. I presume Dr. Lang's restriction of no use of a computer is seemingly based on keyboarding and mousing. Mr. Shockley could certainly use a computer with a voice to text software and could use a keyboard and mouse for less than 1 hour in any 8-hour shift.

The applicant should have the above restrictions from 5/29/2019 on. I would consider this to be permanent work restrictions.

3. Records: Please review the records of Dr. Jamaal's be since her initial evaluation discussed whether any of these records changed any of the opinions outlined in your initial report or any supplemental reports.

Unfortunately, these records have been sent to us in a format that we do not have the capacity to process. I am happy to review the supplemental records when they are sent to format that my office is able to process (i.e., on paper not on CD-ROM).

"I have not violated Labor Code Section 139.3 and the contents of the report and bill are true and correct to the best of my knowledge. This statement is made under the penalty of perjury."

Sincerely,

Adam J. Stoller, M.D.

CC: Mario Castro, Claims Adjuster
James Goines, Defense Attorney
Zachary Kweller, Applicant Attorney